IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
BROWNSVILLE DIVISION

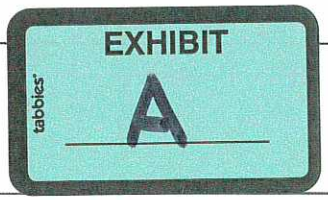
ANA MURILLO Plaintiff	§	
VS.	§	**CIVIL ACTION NO. 1:16-CV-00049**
	§	JURY REQUESTED
RELIANCE STANDARD LIFE INSURANCE COMPANY; DENISE PHILLIPS; AMERICAN FAMILY LIFE INSURANCE Defendants	§	

DECLARATION OF JENNIFER JETER

1. "I, Jennifer Jeter, am over 18 years of age, have never been convicted of a felony or a crime of moral turpitude and am competent to testify. The factual statements in this affidavit are based on my personal knowledge and if called to testify thereto, I could and would competently do so.

2. I am employed by American Family Life Assurance Company of Columbus ("AFLAC"), and I have knowledge of the circumstances of the creation and maintenance of certain of AFLAC's business records, as described in this Declaration.

3. Attached hereto as Exhibit "A-1" to this Declaration is a true and correct copy of the AFLAC "New Accounts Set-up" information document by which AFLAC and Spanish Meadows Nursing Home documented their agreement to have AFLAC provide available insurance coverages to Spanish Meadows employees. As can be seen in the document, Spanish Meadows elected not to authorize disability coverage to be included as part of the original agreement (page 2 of 5). As can also be seen in the document, Spanish Meadows elected to have employees be eligible to obtain coverage under the Spanish Meadows "cafeteria" benefits plan on the first day of the month following 90 days of employment, and elected to have the following



benefits only included in the plan: intensive care, accident, cancer, hospital indemnity, dental, specified health event, and personal sickness indemnity coverages.

4. Exhibit "A-1" is a document which is a type of record kept by AFLAC in the ordinary course of its business; and it was in the regular course of business that an AFLAC employee or representative, with knowledge of the act, event, condition or opinion in the record recorded or transmitted information thereof to be included in the record; and the record was made at or near the time or reasonably soon thereafter. ALFAC maintains either originals or exact duplicates of the originals, and the copy attached as Exhibit "A-1" is an exact duplicates of the original.

5. Attached hereto as Exhibit "A-2" to this Declaration is a true and correct copy of the revised AFLAC "General Accounts" information document by which AFLAC and Spanish Meadows Nursing Home documented the decision by Spanish Meadows to revise the coverages to be offered by AFLAC to include disability coverages as of approximately November 22, 2006.

6. Exhibit "A-2" is a document which is a type of record kept by AFLAC in the ordinary course of its business; and it was in the regular course of business that an AFLAC employee or representative, with knowledge of the act, event, condition or opinion in the record recorded or transmitted information thereof to be included in the record; and the record was made at or near the time or reasonably soon thereafter. ALFAC maintains either originals or exact duplicates of the originals, and the copy attached as Exhibit "A-2" is an exact duplicates of the original.

7. Attached hereto as Exhibit "A-3" to this Declaration is a true and correct copy of the telephone call record documenting telephone calls made by and between Plaintiff and representatives of AFLAC regarding Policy PH649976. As can be seen in the document, an

AFLAC representative advised Plaintiff by telephone on July 30, 2015 of the number, date and type of coverage offered by her policy, including that it was an individual only policy.

8. Exhibit "A-3" is a document which is a type of record kept by AFLAC in the ordinary course of its business; and it was in the regular course of business that an AFLAC employee or representative, with knowledge of the act, event, condition or opinion in the record recorded or transmitted information thereof to be included in the record; and the record was made at or near the time or reasonably soon thereafter. ALFAC maintains either originals or exact duplicates of the originals, and the copy attached as Exhibit "A-3" is an exact duplicates of the original."

9. Attached hereto as Exhibit "A-4" to this Declaration is a true and correct copy of the telephone call record documenting telephone calls made by and between Plaintiff and representatives of AFLAC regarding Policy PW960794, and a true and correct copy of a letter sent to Plaintiff by AFLAC regarding Policy PW960794. As can be seen in the documents, AFLAC responded to Plaintiff's claim for benefits arising from the death of her husband by explaining that Policy PW960794 was issued solely to cover individual Plaintiff Ana Murillo and did not cover Plaintiff.

10. Exhibit "A-4" is a document which is a type of record kept by AFLAC in the ordinary course of its business; and it was in the regular course of business that an AFLAC employee or representative, with knowledge of the act, event, condition or opinion in the record recorded or transmitted information thereof to be included in the record; and the record was made at or near the time or reasonably soon thereafter. ALFAC maintains either originals or exact duplicates of the originals, and the copy attached as Exhibit "A-4" is an exact duplicates of the original.

11. Thus, as set out in AFLAC's documents, AFLAC denied Plaintiff's claims under Policies PH649976 and PW960794 because those policies covered only individual Plaintiff Ana Murillo and not her deceased spouse."

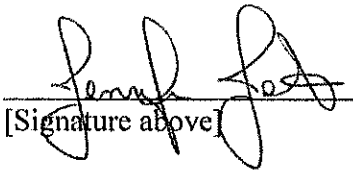
I declare under penalty of perjury that the foregoing is true and correct. Executed on the _____ day of_____, 2017.

_____
[Signature above]

_____
[Printed Name]

11. Thus, as set out in AFLAC's documents, AFLAC denied Plaintiff's claims under Policies PH649976 and PW960794 because those policies covered only individual Plaintiff Ana Murillo and not her deceased spouse."

I declare under penalty of perjury that the foregoing is true and correct. Executed on the 2nd day of February, 2017.



[Signature above]

Jennifer Jeter

[Printed Name]

AFLAC INCORPORATED

AIM

◆ Fax Memorandum ◆

Worldwide Headquarters ◆ 1932 Wynnton Road ◆ Columbus, GA 31999

Phone 1-800-992-3522 ◆ Fax (866) 235-6272 (866-AFL-NASA)

TO:	**New Accounts Set-up**
COMPANY:	**AFLAC**
DEPARTMENT:	**New Business**
FAX NUMBER:	**866-235-6272 (866-AFL-NASA)**
SUBJECT:	Group Name Spanish Meadows Nursing Home
	Group Number #
FROM:	Associates Name John Phillips
	Writing # 46285
	Fax # (956)661-9947
	Phone # (956)661-9900

Date: 09-17-03 / 2nd Fax 09-18-03 Page 1 of 5

Urgent ☑ For your review ☐ Reply ASAP ☐ Please comment

Please check the box below that indicate the form(s) attached to the fax cover sheet. Please include all pages of the forms when submitting. Thanks.

Message:

- ☑ **M0138 – New Account Authorization**
- ☐ **M0135-R – New Account Authorization**
- ☐ **M0486 – Authorization to Include Disability**
- ☐ **S0200 – Adding Benefits Mid-Year**
- ☐ **Letter from Account on Letterhead**

EXHIBIT A-1

661-9947

Payroll Account Acknowledgement

All applicable sections must be completed for processing.

INSTRUCTIONS

- The Authorization and Signatures must be completed for ALL accounts.
- Accounts establishing or modifying a cafeteria plan with FLEX ONE® must complete applicable sections of page 3.
- Accounts with another carrier's cafeteria plan must complete section 8 on page 4.
- Accounts adding AFLAC benefits to another carrier's cafeteria plan mid-year must complete section 8 on page 4.
- Fax completed form to 1-866-AFL-NASA (1-866-235-6272).

1. GENERAL ACCOUNT INFORMATION

☒ **New AFLAC Payroll Account**
☐ **Changes to an existing AFLAC Payroll Account** **Group Number:** _____

Name of Account: SPANISH MEADOWS NURSING HOME
Type of Business: NURSING HOME Tax ID Number: 20-0118715
Industry Classification (contact SIC Team for correct classification): ☐ A ☐ B ☒ C ☐ D ☐ E SIC Record No.: _____
Affiliate/Subsidiary of *(if applicable)*: _____ Master Account No.: _____
Mailing Address: 440 E BJBENM TORRES BLVD.
City: BROWNSVILLE State: TX ZIP: 78520
Location Address: ☒ *(check if same as mailing address (P.O. Box not acceptable))* _____
City: _____ State: _____ ZIP: _____
Phone: (956) 546-7378 Fax *(if applicable)*: (956) 546-8562 Total No. of Employees: 132
Total No. of 1099 Workers: -0- Total No. of W-2 Employees: 132 Will 1099 workers be applying for coverage? ☐ Yes ☒ No

If 1099 workers are applying for coverage, an exception request for payroll rates must be submitted to WWHQ prior to writing the business.

Account Website Address *(if applicable)*: _____

Enrollment Period: *Will the enrollment period exceed 90 days?* ☐ Yes ☒ No *If so, has this been approved by marketing?* ☐ Yes ☐ No
What is the length of the enrollment period? 30
Is there an established New York Account? ☐ Yes ☒ No
If "Yes", provide name and group number: _____

What led your organization to begin offering AFLAC products to your employees/members? *(check all that apply)*
☐ Employee/Member Request ☐ Benefit Package Improvement ☐ Benefit Advisor or Broker Recommendation
☐ Sales Associate/Agent ☐ Commercial Advertising ☐ AFLAC Products are a Good Value ☐ Other: _____

2. INFORMATION CONCERNING TAX STATUS OF DISABILITY INSURANCE BENEFIT PAYMENTS

If disability coverage is funded by employer contributions, pre-tax employee contributions, or a combination of these two, then the disability benefits an employee receives upon becoming disabled will be includible in the employee's income and are fully taxable when paid. In addition, FICA taxes must be withheld and paid on all such benefits during the first 6 months after the disability. Where, as noted below, coverage is funded by employer contributions or employee pre-tax contributions, AFLAC will notify the employer of the amount of disability benefits paid from which the employee's portion of FICA taxes is withheld and will deposit such taxes with the government as required by the Internal Revenue Code. **The employer will be required to submit the employer's portion of applicable FICA and FUTA taxes and report the benefit payments on its Form 941 and the employee's Form W-2.**

Employer authorizes disability coverage to be included as part of this agreement: ☐ **Yes** ☒ **No** *(Base Accident Only)*
- Authorized disability coverage types: ☐ Accident/Disability ☐ Short Term Disability ☐ Off-the-job
- Authorized Riders: ☐ Off-the-Job ☐ On-the-Job ☐ Sickness ☐ Spouse

Will any portion of disability premiums be funded by employer contributions? ☐ **Yes** ☐ **No**
If yes, please provide percent: _____% or flat dollar amount: $ _____
Will any portion of disability premiums be funded by pre-tax employee contributions? ☐ **Yes** ☒ **No**
This Employer is a government employer exempt from FICA or exempt from a portion of FICA: ☐ **Yes** ☒ **No**
Employees of this Employer are eligible for RRTA (Railroad Retirement Tax): ☐ **Yes** ☒ **No**
NOTE: Disability caused by or under certain circumstances will not be covered. Refer to each policy to determine specific coverage, exclusions and limitations.

Account Name: SPANISH MEADOWS NURSING HOME
Tax ID: 20-0118715 Group No.: _____ Writing No.: Y6285

Please consult with Employer's payroll contact to ensure accurate completion of Page 2.

3. BILLING CONTACT INFORMATION

Contact for Billing Inquiries: ☐ Mr. ☒ Ms. MABLE EZEQUIEL
Billing Contact Phone: (956) 546-7378 **Ext.:** 302 **Fax (if applicable):** (956) 546-8562
Billing Contact E-mail: _____
NOTE: AFLAC will contact the Billing Inquiries designee to review billing information.

4. DEDUCTION AND BILLING INFORMATION

Initial Deduction: ***When will premium deductions begin?***

Date of first deduction: 10 / 10 / 03 Date of second deduction: ___/___/___

Invoice Due Date: ***Would you like your first AFLAC invoice to be due on the 1st or the 15th of the month?*** ☐1st ☒15th

Deduction Pay Periods: ***During the year, how many pay periods will include premium deductions?***

Number of annual deduction pay periods: 26

Billing Frequency: ***How often would you like to receive your invoice from AFLAC?***

☐ **Monthly - For accounts with 12, 24 or 48 deduction pay periods indicated above** *(12 invoices)*
☒ **28 Day Biweekly - For accounts with 13, 26 or 52 deduction pay periods indicated above** *(13 invoices)*

☐ 10 Month *(10 invoices)*
☐ 9 Month *(9 invoices)*
☐ 8 Month *(8 invoices)*
For 8, 9 or 10 month, indicate months when no deductions will be made: ☐Jan ☐Feb ☐Mar ☐Apr ☐May ☐Jun ☐Jul ☐Aug ☐Sep ☐Oct ☐Nov ☐Dec

☐ Quarterly *(4 invoices)*
☐ Semi-annually *(2 invoices)*
☐ Annually *(1 invoice)*
For Quarterly, Semi-annually and Annually, initial premiums must be submitted with applications.

Billing Preference: ***Would you like to receive your invoice on*** ☒ ***paper or through*** ☐ ***Internet billing.***

Employer Contributions: ***Does the employer pay any portion of this benefit?*** ☐ Yes ☒ No

If yes, please provide percent: _____% OR flat dollar amount: $_____

5. BILLING FORMAT

In what order would you like your employees listed on your bill? If more than one is checked, please number your choices according to priority.

EXAMPLE: to request a bill with employees listed alphabetically under their department numbers, you would mark:
☒ Alphabetic 2 ☒ Dept. No. 1 ☐ SSN OR Emp. No. _____

☒ Alphabetic 1 ☐ Department No. _____ ☐ Social Security No. **OR** Employee No. _____

Account Name: SPANISH MEADOWS NURSING HOME
Tax ID: 20-0118715 Group No.: _____ Writing No.: 46285

Please consult with Employer's cafeteria plan contact to ensure accurate completion of Page 3.

6. FLEX ONE® CAFETERIA PLAN: ☐New FLEX ONE® Plan ☐FLEX ONE® Plan Change Request
☐Requesting additional payroll account number for existing FLEX ONE®
Plan/Company Name: _____ and Tax ID: _____

Plan Type: ***What type of FLEX ONE® Plan will this be? (Flexible Spending Account = FSA)***
☒ Premium Only - no FSAs ☐Self Administered - has FSAs: Employer processes FSA claims ☐ Full - has FSAs: FLEX ONE® processes FSA claims

Plan Year: What are the dates of this plan? Plan Start Date: 10 / 01 / 03 Plan End Date: 09 / 30 / 03

Plan Sponsor / Legal Representative: ***List the Plan Sponsor and Legal Representative for this cafeteria plan?***
Plan Sponsor/Principal Contact: ROBERTO MARTINEZ
Phone: 956-546-7378 FAX: ( ) _____
Legal Representative Name/Title: _____

Leasing/PEO: ***Is this a leasing company or Professional Employee Organization (PEO)?*** ☐ YES ☐NO

Business Type: ☒Corporation ☐ Sub S Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other _____

Eligibility: Indicate eligibility criteria (e.g., eligibility dates, exceptions) for your cafeteria plan.
Employees shall become eligible on: Immediately upon the first day of employment ☒ On the first day following commencement of employment _____ On the first day of the month following 90 days of employment ☐ Other _____
All employees shall be eligible under the plan except: _____

Benefits: ***Which benefits will be included in this cafeteria plan? (must be qualified under Section 106 of the Internal Revenue Code)***
☐Medical ☐ Long Term Disability ☐ Vision Care ☒ Intensive Care ☐ Short Term Disability ☒Accident
☒ Cancer ☒Hospital Indemnity ☒Dental ☐Group Term Life ☒Specified Health Event ☒Personal Sickness Indemnity

Affiliated Companies: ***List the names and Tax ID numbers of all Affiliated Companies adopting this plan.***
_____
_____

7. FLEXIBLE SPENDING ACCOUNT (FSA) INFORMATION - *Not applicable to Premium Only Plans*

FSA Type ***Which types of FSAs will be included in this cafeteria plan? (complete for both Self Administered and Full Plans)***
☐ § 105 Unreimbursed Medical Expense Annual maximum per participant requested by Employer: $_____
☐ § 129 Dependent Childcare Annual maximum per participant cannot exceed $5000 by law.
Complete Account Type only if "Full Plan" is selected in Section 6.

Account Type ***If you selected the FLEX ONE® Option, you must establish an account from which FLEX ONE® will draw funds for claims payments.***
☐ **Local Account** - you establish a local bank account against which FLEX ONE® is authorized to write checks for the sole purpose of paying participant claims. With this option, reimbursements can be issued **within 2-3 business days.**
☐ **ACH Debit** - you authorize FLEX ONE® to initiate funds transfers from a specified bank account for the sole purpose of paying participant claims. With this option, reimbursements can be issued **within 5-7 business days.**
☐ **CB&T Account** - you establish an account at Columbus Bank & Trust against which FLEX ONE® is authorized to write checks for the sole purpose of paying participant claims.
With this option, reimbursements can be issued **within 10-14 business days.**
☐ **Wire** - Upon notification by FLEX ONE®, you wire funds for the amount of reimbursement payments to FLEX ONE® for distribution to participants. FLEX ONE® is authorized to write checks and to initiate direct deposits to participants for the sole purpose of paying claims. With this option, reimbursements can be issued **within 8-10 business days.***
☐ **Check** - Upon notification by FLEX ONE®, you mail a check for the amount of reimbursement payments to FLEX ONE® for distribution to participants. FLEX ONE® is authorized to write checks and to initiate direct deposits to participants for the sole purpose of paying claims. With this option, reimbursements can be issued **within 14-21 days.***
☐ **Self-Pay** - Upon notification by FLEX ONE®, you issue reimbursement checks to participants. Reimbursements are issued according to **your** timeframe because you are responsible for disbursement. Direct Deposit is not available through FLEX ONE® with this payment option.

*Please note that the timeframe for the issuance of reimbursements is subject to the processing schedule chosen by the employer and the **employer's response time** for funding payment amounts.

Account Name: SPANISH MEADOWS NURSING HOME
Tax ID: 20-0118715 Group No.: _____ Writing No.: Y6285

Please consult with Employer's cafeteria plan contact to ensure accurate completion of Section 8.

8. OTHER CARRIER'S (non-FLEX ONE ®) CAFETERIA PLAN INFORMATION

Current Plan Year dates required: ___/___/___ through ___/___/___
If short plan year, renewal dates required: ___/___/___ through ___/___/___
☐ **Authorization To Add Benefits Mid-Year (complete ONLY if adding benefits to a non-FLEX ONE® cafeteria plan mid-year)**
Effective Start Date of Additional Benefits: ___/___/___ Effective End Date: ___/___/___
Benefits (list of new benefits to be added): _____

9. AUTHORIZATION AND SIGNATURES

EMPLOYER

AFLAC assures you that you will be reimbursed without question for premium you advance for any employee who terminates after the premium is remitted but before payroll deductions commence. AFLAC also agrees to hold you harmless from any claims against you due to any disagreements between your employees and our Company with respect to the coverage provided under our insurance policies issued to your employees except where caused by misconduct or negligence committed by you or any of your employees or violations of your responsibilities under State or Federal laws.

The employer agrees to provide AFLAC (and its agents) with certain personally identifiable information (including, but not limited to, compensation, Social Security Number, addresses, etc) regarding its officers and employees for AFLAC (and its agents) to use in the administration of employer's cafeteria (including health and dependent care FSA) plan and AFLAC products and services and otherwise in accordance with AFLAC's then current privacy policy. The employer represents and warrants that it is permitted to provide such information to AFLAC (and its agents), assumes all liability in connection with the provision of such information, and agrees to indemnify and hold AFLAC (and its agents) harmless from any claims and damages against AFLAC (and its agents) relating to its provision of such information to AFLAC (and its agents).

AFLAC is authorized to offer this insurance program to our officers and employees. I understand that all applicants must qualify for coverage based on each product's underwriting requirements and that payments for such coverage will be deducted from wages and remitted by my organization to AFLAC®.

☐ **Check if Establishing FLEX ONE® Account:** The employer plans to establish/amend a Flexible Benefits Plan in accordance with Section 125 of the Internal Revenue Code (IRC). The employer acknowledges that neither AFLAC nor its agents is providing legal or tax advice nor serving as the plan administrator or a plan fiduciary under the plan. The employer shall be the sole party responsible for establishment of the plan under applicable law. AFLAC shall have no power or authority to waive, alter, breach or modify any terms and conditions of the plan. The employer shall retain all responsibility and liability for the plan, except as may otherwise be specifically agreed to in writing by an officer of AFLAC. The Plan Sponsor/Administrator should consult its own tax advisor regarding the plan and any changes to the plan. The Employer acknowledges receipt of the Summary of Plan Sponsor Responsibilities and agrees to fulfill its responsibilities as stated therein.

Authorizing Officer's Name/Title *(please print)*: ☒ Mr. ☐ Ms. ROBERTO MARTINEZ
Authorizing Officer's Signature: X _____ LUTCF Date: 9/15/03

ASSOCIATE/AGENT

I acknowledge that AFLAC has the sole and absolute right to determine who shall solicit and service payroll deduction accounts, and AFLAC may assign and/or reassign any account for servicing and designate who may solicit applications from persons in the account. I confirm that I am not an employee, officer, director, owner or relative of any of the foregoing (or otherwise a "party in interest" as defined under ERISA). I acknowledge that, for Key Accounts as defined in the Key Account Management Procedures, the proper guidelines will be followed to provide the most efficient service to the account. I confirm that I will register any such account with Key Account Management regardless of whether I utilize their assistance in the overall management and coordination of the enrollment. I understand that I am not authorized to collect premium from this account without specific written approval from AFLAC.

Associate Name: JOHN R. PHILLIPS
Writing Number: Y6285 **Sit. Code:** 0 **Geographical Code:** 16300
Phone Number: 956 6661-9900 **Fax Number:** 956 6661-9947
Broker Information ***(if applicable)*****: Broker Name:** _____
Broker Number: _____ **Sit. Code:** _____ **Level:** _____
Associate Signature: John R. Phillips **Date:** 9-15-03

CHANGE - TO INCLUDE DISABILITY

Payroll Account Acknowledgment

All applicable sections must be completed for processing.

INSTRUCTIONS

- ALL accounts must complete Section 9, the Authorization and Signatures section.
- Accounts establishing or modifying a Flex One® cafeteria plan must complete Section 5.
- Accounts with another carrier's cafeteria plan must complete Section 7.
- Fax completed form to 1-866-AFL-NASA (1-866-235-6272).

1. GENERAL ACCOUNT INFORMATION

☐ **New Aflac Payroll Account**
☒ **Changes to an Existing Aflac Payroll Account** **Group Number:** GX371
☐ **Split or Transferred Account**

Does this account have multiple locations, each requiring an invoice? ☐Yes ☒No

Are there any existing policies to place on this account? ☐Yes ☐No (If yes, submit a list of the policies on a separate page with the Payroll Account Acknowledgment to Aflac WWHQ.)

Name of Account: SPANISH MEADOWS NURSING HOME

Type of Business: NURSING HOME Tax ID No.: 20-0118715

Industry Classification (Contact SIC Team for correct classification.): ☐A ☐B ☐C ☑D ☐E SIC Record No.:

Affiliate/Subsidiary of *(if applicable)*: Master Account No.:

Mailing Address: 440 E. Ruben M. Torres Blvd.

City: Brownsville State: TX ZIP: 78520

Location Address: ☐ *Check if same as mailing address (P.O. box is not acceptable.)*

City: State: ZIP:

Phone: (956) 546-7378 Fax *(if applicable)*: (956) 546-8562 Total No. of Employees: 132

Total No. of 1099 Workers: 0 Total No. of W-2 Employees: 132 Will 1099 workers be applying for coverage? ☐Yes ☒No

*If 1099 workers are applying for coverage, submit an exception request for payroll rates to WWHQ on Form **IN-02-05** prior to writing the business.*

Account Web Site Address *(if applicable)*:

Enrollment Period: *Will the enrollment period exceed 90 days?* ☐Yes ☒No *If so, has this been approved by Sales Support?* ☐Yes ☐No

What is the length of the enrollment period? 30

Is there an established Aflac New York account? ☐Yes ☒No

If yes, provide name and group number:

What led your organization to begin offering Aflac products to your employees? *(Check all that apply.)*
☐ Employee/Member Request ☐ Benefit Package Improvement ☐ Benefit Advisor or Broker Recommendation
☒ Sales Associate/Agent ☐ Commercial Advertising ☐ Aflac Products Are a Good Value ☐ Other:

Please consult with employer's payroll contact to ensure accurate completion of next section.

EXHIBIT A-2

CHANGE - TO INCLUDE DISABILITY

Account Name: SPANISH MEADOWS NURSING HOME
Tax ID: 20-0118715 Group No.: GX371 Writing No.: Y6285

2. BILLING INFORMATION

2a. BILLING CONTACT INFORMATION

NOTE: Aflac will contact the designated Billing Contact to review information.

All accounts with fewer than 1,000 employees will receive their invoice via Aflac's Online Billing system. As an Online Billing account, you have the option of making payments and reconciling your account online. Once your account is established, you can submit your invoice and payment electronically when due from the bank account noted below. At that time, if you prefer, you may also choose to pay by mailing a check. Aflac will not debit your account until you have reconciled and submitted your invoice for payment. Any adjustments or requested changes you submit electronically will not be processed until payment is received and the transaction is complete.

Bank Routing No.: _____ **Account No.:** _____

Account Type: ☐ Checking ☐ Savings

Contact for Billing Inquiries: ☐ Mr. ☑ Ms. MABLE EZEQUIEL

Billing Contact Phone: (956 546-7378 **Ext.:** _____ **Fax** ***(if applicable)***: (956 546-8562

Billing Contact E-Mail *(required)*: _____

☐ Account does not have access to the Internet and/or internal processes prohibit use.

2b. BILLING FREQUENCIES

Invoice Due Date: On what day of the month would you like your Aflac invoice to be due (1st or the 15th)? 15

How often would you like to receive your invoice from Aflac?

☐ Monthly (Aflac will bill for the number of deductions made the previous month. Example: Deductions made January 1st through the 31st will be due in February.)

KEEP THE SAME

☐ 8-Month *(8 invoices)*
☐ 9-Month *(9 invoices)*
☐ 10-Month *(10 invoices)*
For 8-, 9- or 10-month, indicate months when no deductions will be made:
☐Jan ☐Feb ☐Mar ☐Apr ☐May ☐Jun ☐Jul ☐Aug ☐Sep ☐Oct ☐Nov ☐Dec

☐ Quarterly *(4 invoices)*
☐ Semiannually *(2 invoices)*
☐ Annually *(1 invoice)*
For Quarterly, Semiannually, and Annually, initial premiums must be submitted with applications.

2c. BILLING FORMAT

☐ Check if account uses Social Security number for employee number.

In what order would you like your employees listed on your bill?
(If more than one is checked, please number your choices according to priority.)

EXAMPLE: to request a bill with employees listed alphabetically under their department numbers, you would mark:
☒ Alphabetic 2 ☒ Dept. No. 1 ☐ Employee No. _____

☒ Alphabetic 1 ☐ Department No. _____ ☐ Employee No. _____

CHANGE - TO INCLUDE DISABILITY

Account Name: SPANISH MEADOWS NURSING HOME
Tax ID: 20-0118715 Group No.: GX371 Writing No.: Y6285

3. DEDUCTION INFORMATION

Employer Contributions: ***Does the employer pay any portion of this benefit?*** ☐Yes ☒No
If yes, please provide percent: _____% **OR** flat dollar amount: $_____
Percent or dollar amount must be a whole number, such as "50%" or "$10."

Based on the information provided in this section, Aflac will determine the number of deduction periods billed each month (when the account selects monthly billing).

If you choose monthly billing frequency, indicate the number of payroll deductions made annually for insurance premiums. For all other billing frequencies, mark N/A: ☐ 52 ☐ 26 ☐ 24 ☐ 12 ☐ N/A

☐ Check if premiums are deducted at different frequencies for different employees (i.e., some employees are deducted weekly while others are deducted biweekly), and indicate the different frequencies that exist for the account on separate M-0138 applications.

Initial Deduction: ***When will premium deductions begin?*** — ONGOING —

Date of first deduction: _____/_____/_____ Date of second deduction: _____/_____/_____

The date of the first deduction should reflect the date the payroll account physically obtains funds from the employees. It does not necessarily equal the pay date for the employees.

4. INFORMATION CONCERNING TAX STATUS OF DISABILITY INSURANCE BENEFIT PAYMENTS

If disability coverage is funded by employer contributions, pre-tax employee contributions, or a combination of these two, then the disability benefits an employee receives upon becoming disabled will be includible in the employee's income and are fully taxable when paid. In addition, FICA taxes must be withheld and paid on all such benefits during the first six months after the disability. Where, as noted below, coverage is funded by employer contributions or employee pre-tax contributions, Aflac will notify the employer of the amount of disability benefits paid, from which the employee's portion of FICA taxes is withheld and will deposit such taxes with the government as required by the Internal Revenue Code. **The employer will be required to submit the employer's portion of applicable FICA and FUTA taxes and report the benefit payments on its Form 941 and the employee's Form W-2.**

Employer authorizes disability coverage to be included as part of this agreement: ☒Yes ☐No
- Authorized disability coverage types: ☑Accident/Disability ☑Short-Term Disability ☑Off-the-job
- Authorized riders: ☑Off-the-job ☑On-the-job ☑Sickness ☐Spouse

Will any portion of disability premiums be funded by employer contributions? ☐Yes ☒No
If yes, please provide percent: _____% **OR** flat dollar amount: $ _____
Percent or dollar amount must be a whole number, such as "50%" or "$10."

Will any portion of disability premiums be funded by pre-tax employee contributions? ☐Yes ☒No

This employer is a government employer exempt from FICA or exempt from a portion of FICA. ☐Yes ☒No

Employees of this employer are eligible for RRTA (Railroad Retirement Tax). ☐Yes ☒No

NOTE: Disability caused by or under certain circumstances will not be covered. Refer to each policy to determine specific coverage, exclusions, and limitations.

Please consult with employer's cafeteria plan contact to ensure accurate completion of next section.

Account Name: SPANISH MEADOWS NURSING HOME
Tax ID: 20-0118715 Group No.: GX371 Writing No.: Y6285

5. FLEX ONE® CAFETERIA PLAN: ☐ New Flex One Plan ☒ Flex One Plan Change Request ✳
☐ Requesting Additional Payroll Account Number for Existing Flex One
Plan/Company Name: _____ Tax ID: _____

Plan Type: ***What type of Flex One Plan will this be? (Flexible Spending Account = FSA)***

☐ Premium Only – no FSAs ☐ Self-Administered – has FSAs; employer processes FSA claims ☐ Full – has FSAs; Flex One processes FSA claims

Plan Year: What are the dates of this plan? Plan Start Date: ____/____/____ Plan End Date: ____/____/____

Plan Sponsor/Legal Representative: ***List the plan sponsor and legal representative for this cafeteria plan.***

Plan Sponsor/Principal Contact: ROBERTO MARTINEZ
Phone: 956 546-7378 Fax: 956-546-8562
Legal Representative's Name/Title: _____

Is this a leasing company or Professional Employee Organization (PEO)? ☐ Yes ☐ No

Business Type: ☒ Corporation ☐ Sub S Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other _____

Eligibility: Indicate eligibility criteria (e.g., eligibility dates, exceptions) for your cafeteria plan.

Employees shall become eligible: Immediately upon the first day of employment _____.
On the _____ day following commencement of employment.
→ On the first day of the month following 90 days of employment.
Other _____

All employees shall be eligible under the plan except: _____

Cafeteria Plan Benefits: ***(To add, account must be qualified under Section 106 of the Internal Revenue Code.)***

Check plans to add:

☒ Medical ☐ Long-Term Disability ☒ Vision Care ☒ Dental ☒ Short-Term Disability ☐ Health Savings Account
☒ Cancer ☒ Hospital Indemnity ☒ Intensive Care ☒ Group Term Life ☒ Specified Health Event ☒ Personal Sickness Indemnity
☒ Accident

Affiliated Companies: ***List the names and tax ID numbers of all affiliated companies adopting this plan.***

Company Name	*Tax Identification Number*

6. FLEXIBLE SPENDING ACCOUNT (FSA) INFORMATION (*not applicable to Premium-Only Plans*)

FSA Type: ***Which types of FSAs will be included in this cafeteria plan? (Complete for both self-administered and full plans.)***

☐ Section 105: unreimbursed medical expense annual maximum per participant requested by employer: $_____
Will a Grace Period be offered for Section 105? ☐ Yes ☐ No

☐ Section 129: dependent child care annual maximum per participant cannot exceed $5,000 by law.

Complete account type only if Full Plan is selected in Section 5.

Account Type: ***If you selected the Flex One option, you must establish an account from which Flex One will draw funds for claims payments.***

☐ **Local Account:** You establish a local bank account against which Flex One is authorized to write checks for the sole purpose of paying participant claims. With this option, reimbursements can be issued **within 2–3 business days.**

☐ **ACH Debit:** You authorize Flex One to initiate funds transfers from a specified bank account for the sole purpose of paying participant claims. With this option, reimbursements can be issued **within 5–7 business days.**

☐ **CB&T Account:** You establish an account at Columbus Bank & Trust against which Flex One is authorized to write checks for the sole purpose of paying participant claims. With this option, reimbursements can be issued **within 10–14 business days.**

☐ **Wire:** Upon notification by Flex One, you wire funds for the amount of reimbursement payments to Flex One for distribution to participants. Flex One is authorized to write checks and to initiate direct deposits to participants for the sole purpose of paying claims. With this option, reimbursements can be issued **within 8–10 business days.***

☐ **Check:** Upon notification by Flex One, you mail a check for the amount of reimbursement payments to Flex One for distribution to participants. Flex One is authorized to write checks and to initiate direct deposits to participants for the sole purpose of paying claims. With this option, reimbursements can be issued **within 14–21 days.***

☐ **Self-Pay:** Upon notification by Flex One, you issue reimbursement checks to participants. Reimbursements are issued according to your time frame because you are responsible for disbursement. Direct Deposit is not available through Flex One with this payment option.

Account Name: SPANISH MEADOWS NURSING HOME
Tax ID: 20-0118715 Group No.: GX371 Writing No.: Y6285

*Please note that the time frame for the issuance of reimbursements is subject to the processing schedule chosen by the employer and the employer's response time for funding payment amounts.

Please consult with employer's cafeteria plan contact to ensure accurate completion of next section.

7. OTHER CARRIER'S (not FLEX ONE®) CAFETERIA PLAN INFORMATION — N/A

Current plan year dates required: ____ / ____ / ____ through ____ / ____ / ____

If short plan year, renewal dates required: ____ / ____ / ____ through ____ / ____ / ____

☐ **Authorization to Add Benefits Mid-Year (Complete ONLY if adding benefits to a non-Flex One cafeteria plan at mid-year.)**

Effective Start Date of Additional Benefits: ____ / ____ / ____ Effective End Date: ____ / ____ / ____

Benefits (check new benefits to be added):

☐ Medical ☐ Long-Term Disability ☐ Vision Care ☐ Dental ☐ Short-Term Disability ☐ Health Savings Account
☐ Cancer ☐ Hospital Indemnity ☐ Intensive Care ☐ Group Term Life ☐ Specified Health Event ☐ Personal Sickness Indemnity
☐ Accident

8. ASSOCIATE/AGENT

I acknowledge that Aflac has the sole and absolute right to determine who shall solicit and service payroll deduction accounts, and Aflac may assign and/or reassign any account for servicing and designate who may solicit applications from persons in the account. I confirm that I am not an employee, officer, director, owner, or relative of any of the foregoing (or otherwise a "party in interest" as defined under ERISA). I acknowledge that, for Key Accounts as defined in the Key Account Management Procedures, the proper guidelines will be followed to provide the most efficient service to the account. I confirm that I will register any such account with Key Account Management regardless of whether I use their assistance in the overall management and coordination of the enrollment. I understand that I am not authorized to collect premium from this account without specific written approval from Aflac.

Associate's/Agent's Signature: ____ **Date:** ____

Associate's/Agent's Name: JOHN PHILLIPS

Writing Number: Y6285 **Sit. Code:** 0 **Geographical Code:** 16300

Phone Number: (956) 316-0700 **Fax Number:** (956) 316-0022

Broker's Name *(if applicable)*: N/A

Broker's Number: N/A **Sit. Code:** ____ **Level:** ____

9. AUTHORIZATION AND SIGNATURES
EMPLOYER

Aflac assures you that you will be reimbursed without question for premium you advance for any employee who terminates after the premium is remitted but before payroll deductions commence. Aflac also agrees to hold you harmless from any claims against you due to any disagreements between your employees and our company with respect to the coverage provided under our insurance policies issued to your employees except where caused by misconduct or negligence committed by you or any of your employees or violations of your responsibilities under state or federal laws.

The employer agrees to provide Aflac (and its agents) with certain personally identifiable information (including, but not limited to, compensation, Social Security numbers, addresses, etc.) regarding its officers and employees for Aflac (and its agents) to use in the administration of employer's cafeteria (including health and dependent care FSA) plan and Aflac products and services.

Aflac is authorized to offer this insurance program to our officers and employees. I understand that all applicants must qualify for coverage based on each product's underwriting requirements and that payments for such coverage will be deducted from wages and remitted by my organization to Aflac.

☐ **Check if Establishing Flex One Account:** The employer plans to establish/amend a flexible benefits plan in accordance with Section 125 of the Internal Revenue Code. The employer acknowledges that neither Aflac nor its agents are providing legal or tax advice, nor serving as the plan administrator or a plan fiduciary under the plan. The employer shall be the sole party responsible for establishment of the plan under applicable law. Aflac shall have no power or authority to waive, alter, breach, or modify any terms and conditions of the plan. The employer shall retain all responsibility and liability for the plan, except as may otherwise be specifically agreed to in writing by an officer of Aflac. The plan sponsor/administrator should consult its own tax advisor regarding the plan and any changes to the plan. The employer acknowledges receipt of the Summary of Plan Sponsor Responsibilities and agrees to fulfill its responsibilities as stated therein.

Account Name: SPANISH MEADOWS NURSING HOME
Tax ID: 20-0118715 Group No.: GX371 Writing No.: Y6285

Authorizing Officer's Name/Title *(please print)*: ☐ Mr. ☐ Ms. MABLE EZEQUIEL
Authorizing Officer's Signature: Mable Ezequiel Date: _____

Account Name: SPANISH MEADOWS NURSING HOME
Tax ID: 20-0118715 Group No.: GX371 Writing No.: 76285

AFFILIATE NAME	TAX ID	AFFILIATE NAME	TAX ID

Account Name: SPANISH MEADOWS NURSING HOME
Tax ID: 20-0118715 Group No.: GX371 Writing No.: 76285

Group Short-Term Disability Insurance

Number of Eligible Employees at Company: _____ Participation Requirements (%): _____
(A minimum of 30 percent participation is required for all eligible employees.)

Guaranteed-Issue Only:

Benefit Amount	$
Elimination Period (Injury/Sickness)	
Benefit Period	

Simplified-Issue Only:

Benefit Amount	$
Elimination Period (Injury/Sickness)	
Benefit Period	

Group Short-Term Disability Approval Date: _____ / _____ / _____

Group Short-Term Disability Withdrawal Date: _____ / _____ / _____

Dental Requirements

Dental Plan Start Date: _____ / _____ / _____

Dental Plan Stop Date: _____ / _____ / _____

Number of Eligible Employees for Dental at Company: _____ Participation Requirements: _____

Long-Term Care Requirements

Long-Term Care Plan Start Date: _____ / _____ / _____

Long-Term Care Plan Stop Date: _____ / _____ / _____

Revised Personal Short-Term Disability

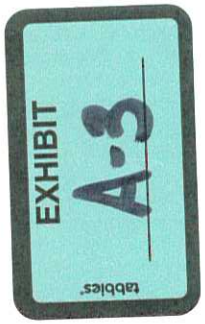
Exempt from Standard Salary Income Chart: _____

Accident/Disability Revised Income Replacement

Exempt from Standard Salary Income Chart: _____

PH649976

Call Date/Time	1/28/2008 2:09:48 PM
Tracking Number	W7B4Q27
Caller Name	ANA N MURILLO
Caller Phone Number	956/831-0857
Caller Type Description	Claims
Insured Name	MURILLO, ANA
Policy Number	PH649976
State	TX
Closed Date	01/28/2008
Desk Code	KES
Employee Enumber	E09985
Employee Job Title	Customer Service Spec III
Employee Work Phone Number	402/392-4999
Supervisor Full Name	Adams,Ritia Maria
Tracking Status	Processed
Call Destinations Description	Call Center
Call Reasons Description	POLICY STATUS



PH649976

Call Date/Time	6/17/2015 6:21:48 PM
Tracking Number	G12J8N5
Caller Name	Murillo, Ana L/

Caller Phone Number	956/404-3068
Caller Type Description	Policy
Insured Name	MURILLO, ANA
Policy Number	PH649976
State	TX
Closed Date	06/17/2015
Desk Code	AI4
Employee Enumber	E14503
Employee Job Title	Customer Service Specialist II
Employee Work Phone Number	
Supervisor Full Name	Michalak,Corinne E
Tracking Status	Processed
Call Destinations Description	Call Center
Call Reasons Description	

PH649976

Call Date/Time	6/17/2015 6:32:08 PM
Tracking Number	G12J8PA
Caller Name	Murillo, Ana L/Self
Caller Phone Number	956/404-3068
Caller Type Description	Policy
Insured Name	MURILLO, ANA
Policy Number	PH649976
State	TX
Closed Date	06/17/2015
Desk Code	JCN

Employee Enumber	E07749
Employee Job Title	Customer Service Spec III
Employee Work Phone Number	402/392-4999
Supervisor Full Name	Murphy Swift,Mary Therese
Tracking Status	Processed
Call Destinations Description	Call Center
Call Reasons Description	

PH649976

Call Date/Time	6/17/2015 10:42:14 AM
Tracking Number	H12JY12
Caller Name	Murillo, Ana L/Self
Caller Phone Number	956/404-3068
Caller Type Description	Policy
Insured Name	MURILLO, ANA
Policy Number	PH649976
State	TX
Closed Date	06/17/2015
Desk Code	J5H
Employee Enumber	E09941
Employee Job Title	Customer Service Specialist IV
Employee Work Phone Number	706/596-3196
Supervisor Full Name	Thomas,Veronica
Tracking Status	Processed
Call Destinations Description	Call Center
Call Reasons Description	

PH649976

Call Date/Time	7/1/2015 3:00:26 PM
Tracking Number	F12TZQC
Caller Name	Murillo, Ana L/Self
Caller Phone Number	956/404-3068
Caller Type Description	Policy
Insured Name	MURILLO, ANA
Policy Number	PH649976
State	TX
Closed Date	07/01/2015
Desk Code	AU7
Employee Enumber	E14996
Employee Job Title	Customer Service Specialist II
Employee Work Phone Number	
Supervisor Full Name	Bray,Rhona Latashia
Tracking Status	Processed
Call Destinations Description	Call Center
Call Reasons Description	

PH649976

Call Date/Time	7/30/2015 2:06:32 PM
Tracking Number	K02V87U

Caller Name	Murillo, Ana L/Self
Caller Phone Number	956/404-3068
Caller Type Description	Policy
Insured Name	MURILLO, ANA
Policy Number	PH649976
State	TX
Closed Date	07/30/2015
Desk Code	KGU
Employee Enumber	E11217
Employee Job Title	Customer Service Spec III
Employee Work Phone Number	402/392-4999
Supervisor Full Name	Murphy Swift,Mary Therese
Tracking Status	Processed
Call Destinations Description	Call Center
Call Reasons Description	

Call Comments

PURPOSE: SUMMARY: VP ADV INS THIS IS AN ACCIDENT POL THAT PAYS FOR ACCIDENT RELATED INCIDENTS..ADV GALBLADDER SURGERY..RAT

Call Comments

-

DATE:6/17/2015

TIME:5:16 PM

E-NUMBER:E14503

DESK:AI4 VP:Y

NAME:Murillo, Ana L

ADDRESS:5331 Amatista Dr,Brownsville, TX 78521-6013

- PolicyNumber; Name; Date of Birth;

********** HIPAA INFORMATION **********

Advised caller about: LOB (Accident), Effective Date (10/01/2006)

Call Comments

-

DATE:6/17/2015

TIME:5:23 PM

E-NUMBER:E07749

DESK:JCN VP:Y

NAME:Murillo, Ana L

ADDRESS:5331 Amatista Dr,Brownsville, TX 78521-6013

- PolicyNumber; Name; Date of Birth;

********** HIPAA INFORMATION **********

Advised caller about: LOB (Accident), File (Lapsed), Effective Date (10/01/2006), Number (PH649976), Policy Mode Premium ($28.70)

Call Comments

-

DATE:6/17/2015

TIME:10:28 AM

E-NUMBER:E09941

DESK:J5H VP:Y

NAME:Murillo, Ana L

ADDRESS:5331 Amatista Dr,Brownsville, TX 78521-6013

- SSN;

********** HIPAA INFORMATION **********

Updated CIF record: Lang: "E" --> "S", Email: "" --> "luismiguelalba@hotmail.com"

Call Comments

-

DATE:7/1/2015

TIME:2:58 PM

E-NUMBER:E14996

DESK:AU7 VP:Y

NAME:Murillo, Ana L

ADDRESS:5331 Amatista Dr,Brownsville, TX 78521-6013

- SSN;

********** HIPAA INFORMATION **********

Other comments: adv clm rec 062915, allow add time for rev

Adv goal for review time for clms is 4 business days

Call Comments

-

DATE:7/30/2015

TIME:1:01 PM

E-NUMBER:E11217

DESK:KGU VP:Y

NAME:Murillo, Ana L

ADDRESS:5331 Amatista Dr,Brownsville, TX 78521-6013

- SSN;

********** HIPAA INFORMATION **********

Advised caller about: Number (PH649976), LOB (Accident), Coverage (Individual), Effective Date (10/01/2006)

PW960794

Call Date/Time	6/17/2015 10:28:54 AM
Tracking Number	G12J2WX
Caller Name	Murillo, Ana L/Self
Caller Phone Number	956/404-3068
Caller Type Description	Policy
Insured Name	MURILLO, ANA
Policy Number	PW960794
State	TX
Closed Date	06/17/2015
Desk Code	ADR
Employee Enumber	E79853
Employee Job Title	Customer Service Specialist II
Employee Work Phone Number	
Supervisor Full Name	Rowe,Judith A.
Tracking Status	Processed
Call Destinations Description	Call Center
Call Reasons Description	

PW960794

Call Date/Time	6/17/2015 6:21:48 PM
Tracking Number	G12J8N5
Caller Name	Murillo, Ana L/
Caller Phone Number	956/404-3068

Caller Type Description	Policy
Insured Name	MURILLO, ANA
Policy Number	PW960794
State	TX
Closed Date	06/17/2015
Desk Code	AI4
Employee Enumber	E14503
Employee Job Title	Customer Service Specialist II
Employee Work Phone Number	
Supervisor Full Name	Michalak,Corinne E
Tracking Status	Processed
Call Destinations Description	Call Center
Call Reasons Description	

PW960794

Call Date/Time	6/17/2015 6:32:08 PM
Tracking Number	G12J8PA
Caller Name	Murillo, Ana L/Self
Caller Phone Number	956/404-3068
Caller Type Description	Policy
Insured Name	MURILLO, ANA
Policy Number	PW960794
State	TX
Closed Date	06/17/2015
Desk Code	JCN
Employee Enumber	E07749

Employee Job Title	Customer Service Spec III
Employee Work Phone Number	402/392-4999
Supervisor Full Name	Murphy Swift,Mary Therese
Tracking Status	Processed
Call Destinations Description	Call Center
Call Reasons Description	

PW960794

Call Date/Time	6/17/2015 10:42:14 AM
Tracking Number	H12JY12
Caller Name	Murillo, Ana L/Self
Caller Phone Number	956/404-3068
Caller Type Description	Policy
Insured Name	MURILLO, ANA
Policy Number	PW960794
State	TX
Closed Date	06/17/2015
Desk Code	J5H
Employee Enumber	E09941
Employee Job Title	Customer Service Specialist IV
Employee Work Phone Number	706/596-3196
Supervisor Full Name	Thomas,Veronica
Tracking Status	Processed
Call Destinations Description	Call Center
Call Reasons Description	

PW960794

Call Date/Time	7/30/2015 2:06:32 PM
Tracking Number	K02V87U
Caller Name	Murillo, Ana L/Self
Caller Phone Number	956/404-3068
Caller Type Description	Policy
Insured Name	MURILLO, ANA
Policy Number	PW960794
State	TX
Closed Date	07/30/2015
Desk Code	KGU
Employee Enumber	E11217
Employee Job Title	Customer Service Spec III
Employee Work Phone Number	402/392-4999
Supervisor Full Name	Murphy Swift,Mary Therese
Tracking Status	Processed
Call Destinations Description	Call Center
Call Reasons Description	

Call Comments

-

DATE:6/17/2015

TIME:10:28 AM

E-NUMBER:E79853

DESK:ADR VP:Y

NAME:Murillo, Ana L

ADDRESS:5331 Amatista Dr,Brownsville, TX 78521-6013

- SSN;

********** HIPAA INFORMATION **********

Other comments: Transferred to 08668

Call Comments

-

DATE:6/17/2015

DATE:6/17/2015

TIME:5:16 PM

E-NUMBER:E14503

DESK:AI4 VP:Y

NAME:Murillo, Ana L

ADDRESS:5331 Amatista Dr,Brownsville, TX 78521-6013

- PolicyNumber; Name; Date of Birth;

********** HIPAA INFORMATION **********

Other comments: t2 adv ph pol lapsed

Call Comments

-

DATE:6/17/2015

TIME:5:23 PM

E-NUMBER:E07749

DESK:JCN VP:Y

NAME:Murillo, Ana L

ADDRESS:5331 Amatista Dr,Brownsville, TX 78521-6013

- PolicyNumber; Name; Date of Birth;

********** HIPAA INFORMATION **********

Advised caller about: LOB (Ordinary Life), File (Lapsed)

Call Comments

-

DATE:6/17/2015

TIME:10:28 AM

E-NUMBER:E09941

DESK:J5H VP:Y

NAME:Murillo, Ana L

ADDRESS:5331 Amatista Dr,Brownsville, TX 78521-6013

- SSN;

********** HIPAA INFORMATION **********

Updated CIF record: Lang: "E" --> "S", Email: "" --> "luismiguelalba@hotmail.com"

Call Comments

-

DATE:7/30/2015

TIME:1:01 PM

E-NUMBER:E11217

DESK:KGU VP:Y

NAME:Murillo, Ana L

ADDRESS:5331 Amatista Dr,Brownsville, TX 78521-6013

- SSN;

********** HIPAA INFORMATION **********

Advised caller about: LOB (Ordinary Life), Effective Date (10/01/2010)

July 22, 2015

Ana Murillo
5331 Amatista Dr
Brownsville TX 78521

RE:	Policy No.:	PW960794 – 20-Year Term Life Policy
	Deceased:	Jose Luis Murillo
	Relationship:	Husband
	Date of death:	September 2009

Dear Ms. Murillo:

Please accept our sincere sympathy in the loss of Jose Luis Murillo.

Our records indicate this policy was issued providing individual coverage on you, Ana Murillo, only. The application did not indicate a request for spouse coverage, nor were we able to locate a request for the addition of spouse coverage. Based on the terms of this policy, no benefits are payable. If you have any information to the contrary, please submit it to our office for review. We reserve the right to further investigate this claim under all applicable policy provisions.

If you need our help or if you have any questions, please visit aflac.com or call us toll-free at 1-800-99-AFLAC (1-800-992-3522). Our customer service representatives are here to assist you Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

Sincerely,

Taneshia Lawrence
Aflac Claims Department